TAYLOR. (I. E.)

Recto-Labial and Vulvar Fistulæ.

BY

ISAAC E. TAYLOR, M. D.,

OF NEW YORK COUNTY.

REPRINTED FROM PROCEEDINGS OF

The New York State Medical Association.

1885.

SURGEON GENERAL'S LIBRARY

332

RECTO-LABIAL AND VULVAR FISTULÆ.

By Isaac E. Taylor, M. D., of New York County.

Read November 18, 1885.

My friend Professor J. W. S. Gouley, whose master spirit of thought and action "called into being" this Association, requested me to present a paper for this meeting. Desirous of giving countenance to the efforts of other gentlemen who are solicitous to advance the interest of this Association and promote its success, small as my efforts may be, I most cheerfully acquiesced in his wish.

Recto-anal fistula is of frequent occurrence.

Recto-vaginal comes next in frequency.

Recto-labial and vulvar fistulæ are infrequent.

I have selected the last of the three different forms of fistulæ, the recto-labial and vulvar, for a few remarks.

The subject is one which merits more attention and consideration than it has received from the profession. The nature of the disease, and the importance of the surgical treatment required to relieve the exceedingly unfortunate and disagreeable sequence of the primary abscess, appear to have been overlooked, or, if not, it must have been considered of very little moment and interest to the medical man, but it is certainly of great importance and consideration to the patient herself. The various diseases arising from the glandular system of the female organs of generation have been and are credited with but slight or no mention by the gynæcologist, and appear to be also by only a few surgical authorities, and those more particularly who have devoted their principal attention and experience to the diseases of the rectum.

SURGEON GEN'L'S OFFICE 352 LIBRARY

The subject is one akin to recto-anal fistula, for which affection, as a general rule, a surgical operation is deemed advisable.

Doubts as to the correct method of treating recto-labial or vulvar fistula are as vague and uncertain at the present day, by some of the highest surgical authorities, as in years "gone by," judging as I do from the history of the subject, and from my own experience. In private practice this form of fistula is considered as seldom met with. I find no gynæcologist who has referred to it, although the origin and cause of it are of frequent occurrence, arising as they do most generally from the glands of Bartholinus or Duverney.

As illustrative of the few surgical writers who have promulgated their views and the method of operating for this class of fistulæ, I recognize Copeland, Brodie, Curling and Quain.

Allingham and Van Buren, Mollière and Gosselin make no mention of the difficulty whatever.

Copeland, during his day, was the first to mention the supposed correct surgical treatment for recto-vaginal fistula; none of his cases, however, were of the true recto-labial class.

Sir Benjamin Brodie, who accepted and sustained the treatment recommended by Copeland, says that "during a period of twenty-five years he had seen but two cases, one of those being a direct recto-vaginal, and the other a recto-labial and vulvar."

Curling refers to one case of recto-labial, and Quain also to one.

Reference to the few historical surgical facts of this class of fistulæ is of some moment and interest, as showing the infrequency of the form. I can not believe that other surgeons or medical men have not met with them; but, if they were recognized, no reference by publication has been made, or they have been passed over in silence, with the thought probably that Nature would in time establish a cure.

In 1866 I presented a short paper on the same subject to the New York State Medical Society, and I now offer before this Association some further remarks relating to the locality, of the frequent cause, and the simplicity of the thought which prompted the surgical operation, *apropos* to the nature of these cases,

and the success, as a general rule, attending so unfortunate and disgusting a disease occurring in the female.

Search through the annals of medical science, or the special works on gynæcology, without an exception, and you will be surprised at the silence respecting the Bartholinus glands, or the tonsillar bodies of the vulva, as they are sometimes called, and the diseases which appertain to them, and more especially the consequences of those diseases.

Take a retrospective view from the pages of Morgagni, Couper, and Haller on the anatomy of these glands, and the astonishment is increased. From the works of John Hunter, and, not to enlarge, we find that small abscesses, he considered, took place in these glandular bodies when the patient had blenorrhagia.

M. Robert, in 1840, called the attention of the profession to the glands of the vulva, but it was more especially to the follicular.

To M. Huguier, in 1848, we owe the credit for inviting the attention, in a special and clear manner, to the diseases of these glands. We all know the great influence physiologically these active glandular bodies play in the female economy.

We also know pathologically how frequent abscesses may and do occur in the labial region, through various causes, and that in almost all the cases a favorable termination is looked for, and ensues; every member of this Association has presumably seen several cases.

From the records and testimony I have adduced of some eminent surgical authorities in private practice, the unfortunate sequel I have to consider is believed to be rare. Huguier, nevertheless, in his memoir on the diseases of the secretory glands of the external organs in the female, acknowledges the not infrequent fact of recto-labial or vulvar fistula occurring as a sequence of abscess of these glands of Bartholinus. With all this he has not suggested any operative or surgical treatment for the benefit of the patient.[1]

[1] "Mémoire sur les Maladies des Appareils Sécréteurs des Organes Génitaux Externals de la Femme."

Labial or vulvar abscesses are most generally considered as of trivial occurrence. Suppuration in the usual time takes place, the abscess bursts, or may be opened by the attending physician, and that is the end of it, or presumed to be so.

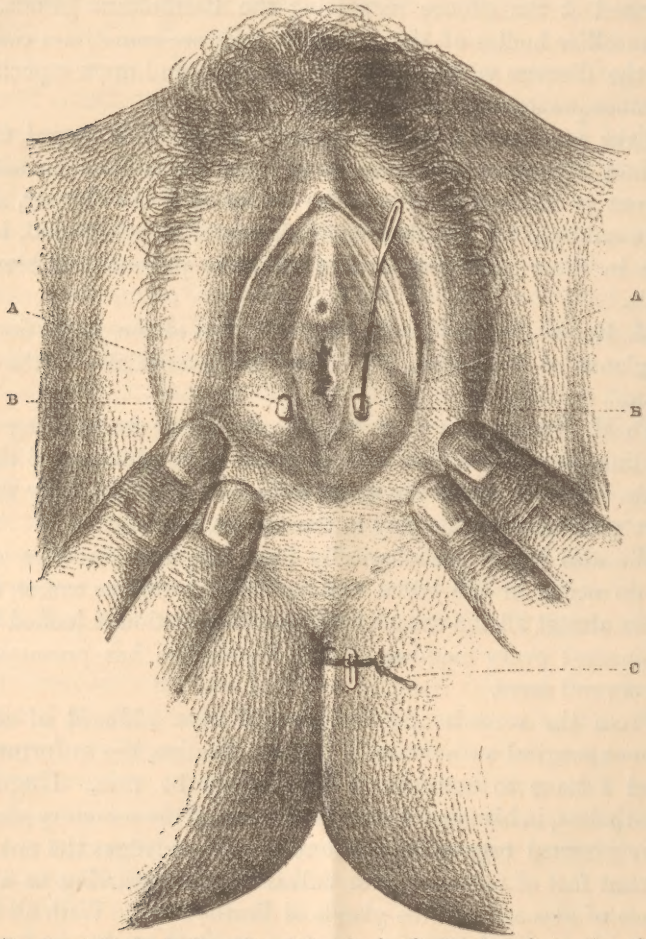

FIG. 1.—A, Probe in the orifice of the gland. B, Gland; inflammation of the duct. C, Ligature, tied and shotted.—(After Huguier.)

Locally these glands, as we are all aware, are situated in the lateral and posterior part of the vagina and vulva, near the

entrance of the vagina, about one third of an inch beyond the hymen and the carunculæ myrtiformes, in the triangular space formed on each side by the union of the rectum and vagina, on which they repose. They are placed between the two superficial and middle layers of the aponeurosis of the perinæum. The minute orifice of the duct of the gland opens at the lateral and inferior part of the vulva, just outside of the hymen and the carunculæ myrtiformes.

In my remarks in this paper I have directed attention solely to the *inflammatory* affections. Under the influence of various causes an inflammatory state of these glands occurs. The inflammation may be confined simply and solely to the excretory duct or the gland itself; eventually the cellular tissue which surrounds the gland becomes implicated. In many cases the abscess originates from the first conjugal approaches, or the act has been repeated many times after short intervals, or from a more direct excitation of the vulva, or from the use of artificial coverings, or the largeness of the male and the smallness of the female organs. Excessive masturbation claims a share in the causes. It is recognized also after confinement. It is seldom the result of extreme violence, or blows, or falls, though they do occur, or it may be through cold.

Labial abscesses, when the areolar tissue is engaged, do not open, as Huguier informs us, on the external face of the labia; they open seldom, or not at all, into the vagina, but on its inner mucous surface, or on the edge of the labia. (See Figs. 1 and 2.) My own experience corroborates this view of Huguier. To account for the *non*-opening of the abscess in the vagina, Huguier says: When the gland is dissected from within outward, we find successively, between the internal face and the vagina, three membranes:

1. The mucous membrane.
2. The proper tissue of the vagina, the fibrous.
3. The expansion which we see on the inferior extremity of the middle layer of the aponeurosis of the perinæum. It is for this reason why the abscess of this organ does not open into the vagina. Now, while the abscess does not open into the vagina,

it does, however, find an opening into the rectum two and a half or three and a half inches high up the gut. (See Figs. 4 and 5.)

To account for this, we should remember that the anterior half of the inferior extremity of the rectum is united, at the posterior part of the vagina, by a cellular tissue on the median line, occupying a space of two and three quarters or three inches in length and one and a half or one and three quarters inches in breadth. It is dense, firm as fibrous structure, and *never fatty*, while outside, or beyond, the tissues become *soft*, *cellular*, and *adipose*, and approaches the lateral sides of the vagina, the rectum, and the excavation of the pelvis. We have, however, another form of abscess and, to all appearance, nearly allied to those arising from the gland—the pre-rectal—and to which Velpeau was considered the first to have called attention. They occupy the lower part of the labia, adjoining the rectum and the anus. They have by some been associated, or mistaken for the glandular abscess. This variety of abscess has for its origin other causes than the glandular, arising chiefly from diseases of the anus, though it may have sprung sometimes from the same causes, most generally from cold, or blows, and other outward influences.

Should an early inflammatory stage of these glands not go on to suppuration, but remain passive, they may become cystic, and, what is not very infrequent, continue in this cystic state for some considerable time, eventually passing into suppuration almost imperceptibly to the patient. (See Fig. 2.)

Should this be the result, the tumor presents the same appearance in form and shape as the early stage of inflammation.

The gland assumes an oval form, about the size of a small egg, presenting no redness on the cuticular surface. It is not painful to the touch on examination, and is movable. It is so movable as to be gently pushed upward to the pubes and downward to the perinæum, and sometimes partially up the rectum. With this feature of the swelling or tumor under examination, it is a very difficult matter to form a true estimate of the case. The movability of the tumor may incline one to consider it a prolapsed ovary, having passed down through Broca's canal,

which commences at the pubes and goes down through the whole length of the labia externa; or it might be viewed as an inguinal hernia, or a hydrocele, as it is in the canal of Broca that serous cysts or tumors occur, and continue for a shorter or

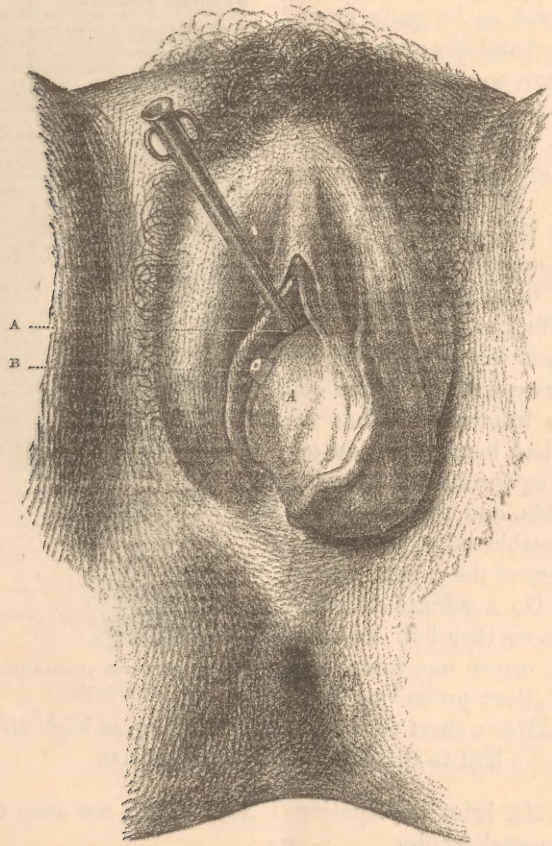

FIG. 2.—A, Catheter in the urethra. B, Gland, cystic.—(After Huguier.)

longer time, and sometimes pass into suppuration. They are a different form of tumor from those which are seen in the canal of Nuck, which seldom or never suppurate. The following case is of some interest, as bearing on this point, the future course and treatment necessary:

Mrs. R. presented herself to me October, 1884, aged twenty-four, single, having a small, egg-shaped swelling or tumor on the right labia. This had existed for several months. On inspection and by manual examination, it was found to be quite movable upward and downward in the labia; gave no uneasiness to the touch; had no redness; was not very firm to the feel. Internal examination gave no pain or uneasiness. No marked translucency of the swelling. I was strongly inclined to the view that it might be a prolapsed ovary existing in Broca's canal. The patient was requested to see me again in two weeks. When she came, she informed me that the swelling had burst, and now *air* was passing through the opening in the labia, and that there was a disagreeable odor sometimes. The history of the patient proved correct. On a minute examination for more than half an hour, the labial orifice was found and the finest silver probe was introduced. After a short time, the rectal opening, as high up the gut as two and a half to three inches, was recognized.

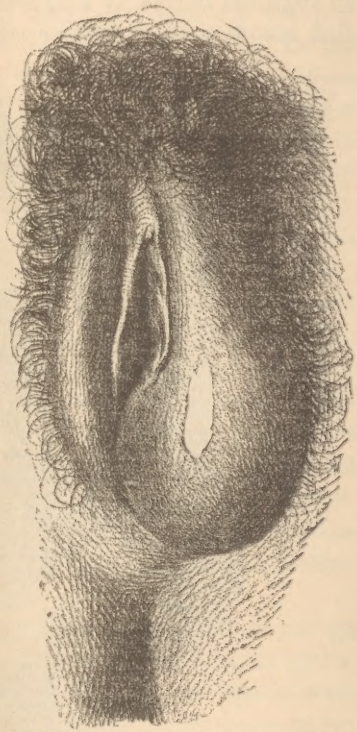

FIG. 3.—ABSCESS OF GLAND. (After Huguier.)

With the brief explanation I have given, we may consider the labio-rectal fistulæ

1. As arising from the gland itself.

2. As implicating the areolar tissue surrounding the gland, and as—

3. The pre-rectal.

From the anatomical conformation of the lower part of the vulva and rectum, as referred to, engaging the perineal space,

we have the recto-labial or vulvar abscess making its way along the lateral sides of the vagina, and finally finding an exit or outlet as high up the rectum as two and a half or three and a half inches. The pre-rectal finds an exit just above the internal sphincter, and which, as a general rule, it does, or between the internal and external sphincters. (See Fig. 5.) It is as customary (so far as my experience goes) for the recto-labial opening to be found high up as it is natural for the pre-rectal to be low down in the gut.

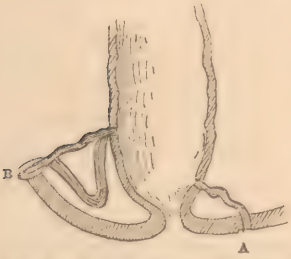

FIG. 4.—A, Anal fistula. B, Labio-rectal fistula.

Recognizing this important fact, it makes the attempt to find the rectal opening very easy and distinct. The sinus arising from the gland itself, or when the areolar tissue surrounding the gland becomes involved, may be almost direct. Most generally it has a long, circuitous course. It passes down from the

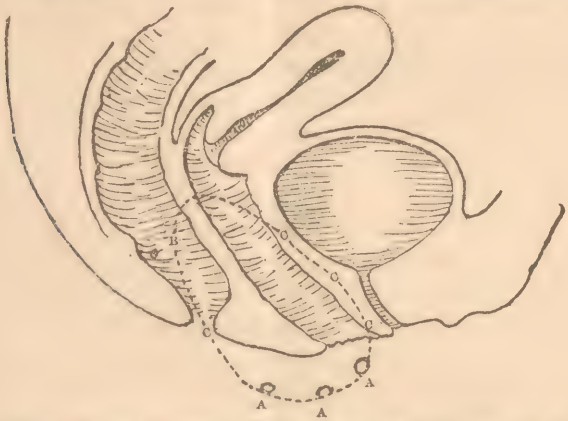

FIG. 5.—A, Labial orifices of abscess. B, Rectal opening of abscess. C, Dotted line of abscess.

external or labial opening to the perineal space, then travels up beside the rectum, and opens either laterally or posteriorly into the gut, at the height referred to—two and a half or three and a half inches—and ranges from three to four inches in length.

The labial or vulvar orifice of the sinus may be where the orifice of the duct of the gland is located, or it may be midway, and in some instances as high as the urethra. (See Fig. 5.) The size of the orifice in the labia is generally very small, and so minute in some cases as to require from one half to three quarters of an hour to discover it, and then the orifice will only admit the smallest silver wire to be introduced. At times a valvular opening exists. It is seldom the labial or rectal openings are as large as a small split pea, and a large silver probe could be inserted easily.

The pathognomonic symptoms of air or gas or very liquid fæcal matter can not be mistaken, as they prove that a fistulous communication exists between the rectum and the labia.

The fact that air has passed through the labia or vulva, even if fluid fæces have not (the taint will establish the fact), demands an investigation to corroborate the symptoms.

I have no doubt that this class of fistula has existed where it was supposed that the case was one of physometra or air from the vagina, which we sometimes meet with, and, should an investigation be made, it would be found to be correct.

When I have asked the question of some of my gynæcological as well as surgical friends, How they would treat such a case as recto-labial or vulvar fistula—the labial orifice of the sinus being midway on the labia, or near the urethra, or as low as the fourchette, and the rectal opening as high as two and a half or three and a half inches—the reply has been:

By Some.—Divide the intervening structures, the vagina and perinæum, and then close the divided parts by suture, the same as for lacerated perinæum, completely through the sphincter ani.

By Others.—Place the patient in the genu-pectoral position, use Sims's speculum, denude the edges of the rectal opening, and close by suture.

By Others again.—Divide the whole sphincter ani, internal and external muscles on both sides, as for fistula in ano.

It must be apparent that neither of these methods could, on mature reflection, be entertained, or, if they were, could be successful.

The *first opinion* militates against the usually accepted and sustained views of the best surgical authorities.

The *second* view of the case, respecting denuding the edges of the rectal opening and then closing it by suture, is purely theoretical, and I am not aware that such an operation could or would be attempted.

The *last*—complete division of the sphincter ani, through both sphincters—might be, but the hæmorrhage would be so great as to preclude it entirely.

In my remarks on this subject I desire to exclude the direct recto-vaginal fistulæ consequent on traumatic causes, whatever they may be.

I make exception, however, only for those cases where a minute labial opening exists near the fourchette, and where it is possible a favorable result might or would be expected, but avoiding too free and deep division of the parts.

Respecting the *cause* producing these recto-vaginal and labial abscesses, Sir Benjamin Brodie, nevertheless, entertained an entirely different opinion. I find he is the principal exponent, more than any other whom I have consulted, who has referred to them. The opinion as to the cause, which he held at that time, was very indefinite, and he evidently had no just comprehensive view of the nature, the true and correct cause of the class of abscesses which take place on the labia, nor in the region of these parts, nor had other surgeons, from the pathological view of the abscess then held, until M. Huguier, in his inestimable monograph referred to, demonstrated the true cause so clearly, as well as the unfortunate results arising therefrom, as a sterco-vulvar or labial fistula.

Brodie, acknowledging this form of recto-labial fistula, remarks: "Now there is another form of fistula that requires very special notice. I can not do better than to mention the following case." I quote this case, for it casts considerable light on the views that were held at that time on this affection, and the method of operation resorted to:

There was a middle-aged lady who had an abscess formed in front of the rectum. I imagined it arose from *ulceration of the*

gut. The abscess burst close by the posterior margin of the vagina, and appeared just like a common fistula. She consulted a surgeon, who inadvertently treated it as such and laid it open into the gut.

But what was the consequence? He divided both the sphincters ani and vagina, and the wound never healed perfectly, and all the rest of her life was miserable.

He says: "I saw this case in 1846, and it was a lesson to me ever afterward." Brodie, remarking on the cause of this case, says: "It is not very often that abscesses of the rectum *do burst* in this situation. I have only seen a few instances of it." Brodie considered that the origin of the abscess was "from an *ulcer* of the mucous membrane of the bowel, extending through the mucous membrane into the cellular tissue external to the intestine." But, still further on, he says: "It is impossible to understand why suppuration should take place in the vicinity of the rectum more than in any other part of the body, and why the cellular membrane *there* should suppurate more than the cellular membrane elsewhere." I have only had a few examples of it. Now how is such a case to be treated? He relates the following:

A lady consulted me with a fistula, communicating with the rectum in front, and opening externally. I made a free division of the sphincter muscle on both sides, so as to set it completely at liberty. I dressed the edges of the muscular sphincter, and it was a good while before it regained its complete usefulness. Five months afterward it was just healing.

He says: "I was led to adopt this method of operating, as it was the one pursued by Copeland." Curling met with, in 1851, a case of a young married lady, who had not only a fistula which opened by the side of the rectum, but another within the vagina, and a *third* opened in the lower part of the labia. An operation was suggested, but declined. Curling, remarking on this case respecting the operation necessary, says: "That when both the sphincter ani muscles are divided, it is found that the patient loses the power of retaining the fæces." It is unneces-

sary to select further quotations from any other writers on this important point of surgical treatment, in cases so closely allied to the class I have under consideration, as they are sufficient to illustrate some of the objects I have in view, the cause and the treatment from such eminent surgeons.

In *marked contrast* with these erroneous views as to the cause as well as the proper treatment of abscesses of the vulva and labia and the sequences attending them sometimes, and as bearing on the method of surgical treatment, I refer to the views and opinions of Professor J. Rhea Barton, of Philadelphia, published in the "American Journal of Medical Sciences," as far back as June, 1839. The title of Barton's paper was "A Recto-vaginal Fistula Cured," but it was a labial fistula, as he remarks elsewhere. It should have been called a recto-labial fistula.

At this point I can only express my surprise at the omission or the non-recognition of his views and opinions, and the operation he performed, as it antedates Brodie's, Curling's, and Quain's, as it merited attention and consideration from the simplicity of the *idea*, which prompted an operation which resulted so favorably for his patient after many years of suffering, and instituted the true and correct course of treatment. It is an operation I have pursued since 1844 in more than forty cases, and I therefore have no hesitation in advocating its claims for recognition and trial should any of you meet with cases of a like nature. It was the only and first case of Barton's—now over forty-six years ago—and, as it may not have been seen by only a few or possibly none of the members present, I trust I shall be excused for introducing it in all of its details, as the subject is so important and interesting:

In June, 1835, an unmarried lady, aged twenty-two, experienced all the symptoms of an acute abscess in the region of the rectum and vagina. It formed and broke on one side and was lanced on the other. After a copious discharge of its contents, one of the openings healed, while the other became fistulous and remained so for four years, resisting all treatment—iodine, caustic, excisions, injections, tents, and setons. She came to Philadelphia

from Baltimore. The *fistula was found commencing about three fourths of an inch within the labia of the right side*, then passing by a very *irregular* course up the pelvis, and inclining to the rectum, into which cavity it finally opened *about* three and a half to four inches from its inferior aperture in the vagina. Through the sinus there issued *fluids* in sufficient quantity to keep the genitals continuously moist. Flatus also at times found its way through this channel.

It was apparent that this sinus could not be included in a seton, and *ulcerated through*, nor be laid open as is usually done in the common fistula in anal cases, without destroying the perinæum, and laying these *two great* cavities into one, thereby causing a more unhappy state of the parts than had formerly existed. The duty of the surgeon, therefore, was very clear: either to consign the patient to a continuance of her loathsome complaint, or to adapt an operation to her *peculiar* case. A fine tent was for a *few days* introduced to dilate the sinus, and to render its course less tortuous. A seton was then inserted into the sinus, with an eyed probe through its whole extent, until it had penetrated the rectum by the orifice in that cavity three and a half inches up. It was then brought down through the rectum and anus. The two ends were then loosely tied together, merely for security against its slipping out. After a few days the *end* of the *seton* passing out of the vagina was put through the eye of a probe which was previously crooked at the end. The probe was then inserted into the orifice of the labia, then its point directed toward the perinæum, just external to the sphincter ani muscle. Here a small but deep incision was made, and the probe passed through it, bringing along with it the end of the seton, which had doubled on itself. The seton now descended through the new channel which was made fast. The ends were now tied, in which were included the portions between the outer surface of the sphincter, and twisted tighter and tighter from time to time, in order to cause its ulcerating through the included parts, as we do in common fistula in ano.

The end which I desired to accomplish by *my operation* was to establish a freer and more direct passage for the escape of the fluids by the rectum than that by the vagina; the sinus opening into this cavity would heal *sua sponte* and become permanently

obliterated, and which proved successful. One year after Dr. Barton was informed that the patient had continued perfectly well.

The question which Brodie asked, "How is this variety of fistulæ, the recto-labial, to be treated?" is, at the present day, just where Sir Benjamin proposed it in 1845, forty years ago. Brodie advocated the operation of Copeland. Copeland's operation was, as I have stated, for direct recto-vaginal fistula, consequent on tedious labors or on traumatic causes, which would at the present day be treated the same as for vesico-vaginal fistula. Brodie's case, which he operated on for recto-labial fistula, took five months before it was cured.

When Curling, in 1851, and Quain, in 1854, issued their surgical works on rectal diseases, it was twelve to fourteen years after Barton's case was published, but no mention or reference was made to Barton's view of this kind of fistula, and the method of operating. Possibly because they may not have seen it, or, if they had, they had passed it by as of no moment and little value.

Many times in medical or surgical practice an original idea respecting a new operation of a surgical nature will, from the simplicity of the suggestion, without much reflection on the part of the reader on the subject, be set aside or rejected as unworthy of consideration, and that too without giving any attention, and without any experience in relation to the subject.

The class of cases under advisement are in close alliance in appearance to the ordinary fistula in ano, and for this reason it is presumed they would necessitate the same kind of operation.

They are nevertheless entirely different, and require a more conservative surgical treatment by an operation unattended with any unfavorable contingency, consequent on an operation where the rectal opening is as high up the gut as two inches and a half to three inches and a half, and the external on the labia midway, or near the urethra, although that is only occasionally so.

Allingham says: "In operating on women suffering from fistula, and when it is especially near the perinæum, cut as little as possible, for anything like the free division is apt to lead to

incontinence of fæces, or, at all events, in such patient's loss of power in the sphincter as to prevent retaining flatus, etc. It behooves us, therefore, to consider how much we dare do without danger of damaging or destroying the power of the muscles at the outer end of the rectum. In the complaints of this nature, as the division of the parts, where the internal opening is *high* up the gut, it would not be safe."

Brodie affirms: "Suppose the fistula is high up by the side of the rectum, I used to imagine it was necessary to lay open the whole sinus into the rectum, but it is a frightful operation to lay open so long a sinus."

Quain: "Such an operation is dangerous on account of the hæmorrhage which follows any long sinus in the rectum."

Curling: "When the opening is in the rectum more than *two inches and a half* above the external sphincter, the division can not be made without risk of hæmorrhage, and death has happened after the division of a rectal fistula high up, and I have seen one case of it and know of two others."

I can bear personal testimony to the truthfulness of this remark. A patient of Dr. A. H. Stevens died a few hours after the operation, and two others also met a like fate a week after operations—all from loss of blood.

I have intentionally selected these few remarks from these distinguished authorities as useful and pat to the object I have in view, opinions which I believe nearly all present may coincide with, and no doubt sustain by their own experience.

Mr. Luke, of the London Hospital, is thought to have been the first to recommend, when the rectal opening was high up the gut, to resort to the ligature, as I presume you are cognizant of.

That was in 1845; Barton's case, however, was operated on six years before, as the case was published in 1839; Barton's case being far more interesting, instructive, unique, and rare at that time.

By way of exclusion, therefore, the unpleasant and unfavorable results from the use of the scalpel for ordinary fistula in ano, and where the rectal opening of the sinus is two inches and

a half or three inches and a half as in recto-labial fistula high up, the ligature must naturally commend itself. An old but bold French surgeon considered it was, and should be resorted to by the *timid* practitioner only. Pott, an English surgeon, says: "The terror which a cutting instrument carries with it, the fear of a flight of blood from some considerable vessels, produced the coarse and unhandy method of ligature."

Barton used the silk as a ligature, and this was the material I first tried. The silver wire I also resorted to. The objections to these substances since the important discovery of the elastic ligature are many, and they should not be given the preference over the other articles, since they require almost daily visits for purposes of the tightening or twisting when they are cutting their way through the structure embraced in the ligature. In my last two cases the elastic ligature was selected. Holthouse, of London, was, I believe, the first to use it for fistula in ano. It is very strongly advocated by Professor Dittel, of Vienna. Approved highly by Courty, of Montpelier, and finds in Allingham an experienced approver.

The advantages in those cases of fistula in ano requiring the use of the ligature in preference to the scalpel are very valuable, and especially so in the recto-labial or vulvar fistula.

Very little pain is experienced from its application. In fact almost none at all.

The pressure of the thread on the structures to be cut through may not be always the same during the progress of cutting its way through, for the pressure becomes less as the space to be divided is diminished on account of the strength and size of the ligature.

In some cases the patient, as Courty says, has gone on with his business after the application, and physicians who have been operated upon have pursued the rounds of their professional duties without any trouble or unpleasant inconvenience.

The *time* occupied for the ligature to accomplish its work is from three to six days, according to the smallness of the structures to be divided, their firmness and thickness. Sometimes it has taken from seven to eight days. The elastic thread may

sometimes cease its pressure and require the trifling remnant of the structure to be divided or simply nicked to free the ligature.

Now *how* shall the elastic ligature be introduced in this class of fistulæ? Allingham has suggested an instrument for this purpose, in cases of fistula in ano. The instrument of Allingham can not be available in recto-labial fistula. It is too large at the extremity, and its size, to be inserted through such narrow fistulous tracks as exist in these fistulæ.

I have given the preference to a small, slight, ductile silver probe instead, and I have not found any difficulty, though it requires a little time to accomplish its task. There are two different ways of passing the ligature:

The first is that which Barton adopted, and which may be considered by some as the best, and to appearance the easiest and most simple. Recognizing the locality of the rectal or internal opening by introducing the silver probe of moderate size and proper length, with the eye of the probe threaded with the elastic ligature, into the labial or vulvar orifice, direct the probe to the internal or rectal orifice of the sinus, then with the left forefinger introduced into the rectum, having felt the probe, bend it and bring it down through the rectum and out of the anus. Withdraw the probe, having left one end of the ligature out of the anus and the other out of the labial orifice, remove the probe, then introduce it again into the labial opening, pass it down along the perinæum till it reaches just outside of the sphincter ani, low down, then cut on the end of the probe and draw the ligature through the new channel with the end of the ligature which was at the labial orifice left after the first introduction in the labia. The ligature is then tied, shotted and clamped, and the ends clipped off, and the patient returned to the bed. (See Fig. 1.)

The *second* method, and the one I have most usually followed:

The usual surgical silver probe is introduced into the labial orifice, pressed down to the lower part just outside of the sphincter ani, the end is then cut upon, then withdrawn, and a more

slender, ductile one substituted, and passed up to the rectal opening through the sinus, having the eye threaded with the ligature; the finger is introduced into the rectum, recognizes the probe; this is curved, and gradually and gently drawn

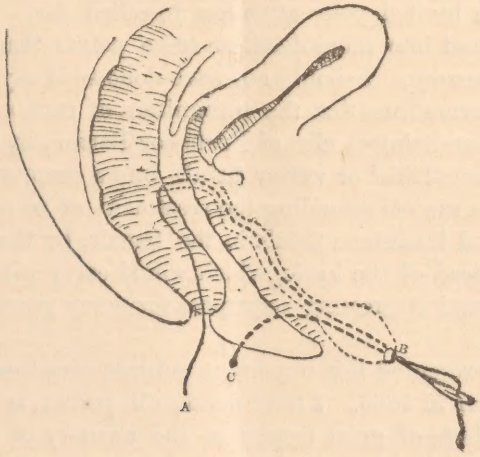

FIG. 6.—A, End of anal ligature. B, End of labial ligature. C, Perineal ligature, as passed.

through the rectum and anus. The two ends are then tied, shotted, and clamped, to make it more secure. When the external artificial opening is made, it is apparent that we now have simply an ordinary fistula in ano, with an internal or rectal orifice high up the gut.

The question has often been put to me, What do you do do with the labial orifice, as you now have three openings? The fact must be self-evident: it takes care of itself. In a few days, or at most two weeks, the sinus or fistulous opening will be perfectly closed, for just as soon as the rectal opening is united and the ulceration or sinus gradually healing up, there can no more air or fluid fæces enter and pass through the sinuous tract out of the labial orifice.

Nothing more is requisite to be done after the operation than to have either warm or cool applications, agreeably to the sensations of the patient, made with simple water, several times

during the day. Should the patient require an anodyne, it can be given, but it is not always necessary. In a few days the elastic ligature will have cut its way through the intervening structure involved in the ligature.

Possibly, gentlemen, I have been more prolix than the subject I have invited your attention to called for. I am aware I have entered into more detail on some points than might be deemed necessary. I should not have done so if my experience had not informed me that the recognition of such a clear, comprehensive, and simple idea of Professor Barton, by the conversion of a recto-labial or vulvar fistula into a common fistula in ano, and the success attending the treatment of so rare and unfortunate and loathsome fistula in the female, by the use of the ligature instead of the knife, which would carry with it, a most lamentable and distressing sequence, for many years, if not for a lifetime.

I have presented this important subject afresh to you, since my last paper in 1866. I have done so in justice, as I conceive, and as a tribute of great respect to the memory of one of my first teachers when I entered as a student in the medical profession, though having seen many more cases than he had, as he had had but a single instance of the affection. My experience for over forty years ratifies in my own mind the correctness of his original idea, and confirms the great utility and benefit it creates for the suffering patient. It is due to his memory, for he was one of the most eminent surgeons during his day—conservative in his views respecting his surgical cases—brilliant in his operations, and exceedingly successful in the result of them.